Health care reform update

Minimum Value Plan Status

Background

The Affordable Care Act (ACA or health care reform law) added a section to the Fair Labor Standards Act (FLSA) that said an applicable employer (those with 50 or more full-time or full-time equivalent workers) must provide a written notice notifying workers of the option they have to purchase insurance through the new health insurance marketplace (also known as the exchange). This notice had to be given to existing workers by October 1, 2013, and has to be provided to new workers within two weeks of the date they start work.

The model health insurance marketplace coverage options notice templates have a checkbox for employers to check that says:

- If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

The Department of Labor (DOL) Employee Benefits Security Administration (EBSA) released guidance on the Notice of Coverage Options in the form of a frequently asked question. The guidance says that a covered company should provide a written notice to its employees about coverage options and eligibility for premium assistance in the health insurance marketplace by October 1, 2013, but if it doesn’t, there are no fines or penalties for not giving out the notice.

Key Points regarding Minimum Value (MV) in general

- The minimum value (MV) provision is applicable to plan designs from 2014 and each year after.
  - MV applies to plans with a new or renewing effective date of 1/1/2014 and later.
- MV applies to all group sizes. It does not apply to individual plans.
- All non-grandfathered small group plans must meet the 60% MV level.
- The majority, but not all, of non-grandfathered large group plans must meet the 60% MV level.
- We will calculate MV for all grandfathered and non-grandfathered small group and large group fully-insured plans from 2014 and each year after—both standard and custom, as long as there are no carved-out benefits.
- Self-funded groups and groups with carved out benefits should consult a tax advisor or may consult another third party to see if their plan meets MV, or use the MV calculator HHS created. We will not calculate MV for self-funded plans.
- We do not calculate or provide MV status for any 2013 plan, regardless of market size.

Key Points regarding the Summary of Benefits and Coverage (SBC) and Minimum Value (MV) certification

- SBCs we create for standard plans use the 2014 template, which adds two questions to page 4 of the form, asking if the plan meets MV and minimum essential coverage (MEC).
- We calculate MV for fully-insured plans—both standard and custom, as long as there are no carved-out benefits. We indicate the MV status on the SBC for these plans.
  - We do not have a way to calculate MV for groups that carve out benefits like pharmacy or mental health.
- We calculate MV for fully-insured grandfathered plans. Grandfathered plans can use the model notice for employers who offer a health plan or a cover letter with open enrollment materials to let employees know if the plan meets minimum value, since SBCs are not required for grandfathered plans until 9/23/2014.
- We will not indicate MV status on the SBC for self-funded plans or those with carved-out benefits.
  - Employers can create a cover letter about MV to go with the SBC. This is allowed by the federal agencies. Information that must be included in the cover letter can be found in the DOL FAQ Part XIV (and below).
Questions and Answers

Q. What is minimum value (MV)?
A. Minimum value means the plan has to pay for at least 60% of covered benefits.

Q. What does “MV status (pass/fail)” mean?
A. It means that the plan meets minimum value (pass) or does not meet minimum value (fail). This information is important to workers who want to know if they can get financial help in the form of a subsidy if they buy a plan from the health insurance marketplace.

Q. What is minimum essential coverage (MEC)?
A. Minimum essential coverage (MEC) is defined in the health care reform law as:

- Coverage under certain government-sponsored plans (like Medicare, Medicaid or Children’s Health Insurance Plans (CHIP))
- Employer-sponsored plans that are not made up of only excepted benefits (like hospital indemnity, stand-alone dental, stand-alone vision)
- Plans in the individual market
- Grandfathered health plans
- Any other health benefits coverage that is recognized by HHS

Q. What is the definition of a fully insured plan for MV calculation purposes?
A. Fully insured plans are as defined by the state Department of Insurance (DOI). Please ask your sales representative if you have a question.

Q. What is a custom plan?
A. A custom plan is one that includes features different than those plans that are included in our standard large group product portfolio. Custom plans usually have to go through a special review and approval process.

Q. Do employers have to use the model health insurance marketplace coverage options templates provided by the DOL?
A. No. The templates are just a guide employers can use. There are three things that do have to be in the notices:

1. A description of the health insurance marketplace and how employees can get more information.
2. Possible eligibility for a premium tax credit if the employee purchases a qualified health plan through the marketplace.
3. An explanation that the employee may lose what the employer pays (if anything) toward health benefits the employer offers, and that some or all of that money may be left out of income for federal income tax reporting purposes.

Q. If employers want to use the template, do they have to check the box that includes the phrase “meets the minimum value standard”?
A. No.

Q. Do you help an employer figure out if their 2013 plan meets minimum value so they can check the box on the notice?
A. No. 2013 plans are not subject to MV. The MV calculator can only be used for the most basic plan types. We do not have the tools or resources to calculate MV for 2013 large group plans. There are currently no tools that provide this calculation for 2013 small group plans.
Q. Are you going to figure out MV for 2014 and each year after?
A. We calculate MV for custom fully-insured plans as long as they do not have carved-out benefits. There is simply not a way for us to calculate MV for plans with carved-out benefits. We will not calculate MV for self-funded plans.

Q. Are there other ways to determine if a plan meets the MV requirement?
A. There are four ways to calculate MV:
   1. Using the MV calculator (this is the method we use to calculate MV for fully insured plans)
   2. Use of a safe harbor (if available)
   3. Having a credentialed actuary do a calculation and certification
   4. Using a small group metal level plan (the employer’s benefits must mirror the small group plan)

Q. Will an employer group get a penalty if it has a fiscal year plan with an anniversary sometime after 1/1/2014, and one or more employees get a premium tax credit for a plan bought through the health insurance marketplace (also known as the exchange)?
A. No. The employer will, however, get a notice from the state marketplace, and may have to fill out a form that provides information for the marketplace to determine if the employee is eligible for a subsidy.

Q. What changes were made to the SBC template pertaining to MV?
A. Two questions were added to page 4.
   - **Does this Coverage Provide Minimum Essential Coverage?**
     The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” This plan or policy [does/does not] provide minimum essential coverage.
   - **Does this Coverage Meet the Minimum Value Standard?**
     The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage [does/does not] meet the minimum value standard for the benefits it provides.

Q. What information about MV needs to be included on the cover letter that goes with SBCs for self-funded or fully-insured custom plans with carved-out benefits?
A. The same information as above. This information will not be included on SBCs we create for self-funded or fully-insured custom plans with carved-out benefits.
   - **Does this Coverage Provide Minimum Essential Coverage?**
     The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” This plan or policy [does/does not] provide minimum essential coverage.
   - **Does this Coverage Meet the Minimum Value Standard?**
     The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage [does/does not] meet the minimum value standard for the benefits it provides.

Q. Will you indicate MV “pass/fail” status on the SBC for self-funded plans or plans with carved out benefits?
A. Only if we get something in writing from the group with the pass/fail status information (an email from a company employee with authority to give this information is allowed).
Q. Where can more information be found on the notices and templates?

A. Information can be found on the Department of Labor website, Employee Benefits Security Administration, Health Reform page under the heading Notice to Employees of Coverage Options under the Affordable Care Act Regulations heading. Notices are available in PDF and MS Word format in English and Spanish for:

- Employers who offer a health plan to some or all employees – English, Spanish
- Employers who do not offer a health plan – English, Spanish
- COBRA election – English, Spanish

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